

A Review of Elder Abuse Literature: An Age Old Problem Brought to Light

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Abstract

As the population continues to age, elder abuse is an issue that must not be ignored. Although elder abuse is not entirely a new issue, it is time for a unified definition to be identified, prevention programs to be implemented and effective interventions to emerge. This paper provides a synopsis of elder abuse through a comprehensive review of literature. Factors associated with defining elder abuse, types of abuse among the elderly, varying perceptions of elder abuse, perpetrations and situations of elder abuse, recognizing elder abuse, responding to and reporting elder abuse, and interventions and elder abuse are presented. Suggestions for further initiatives are provided.

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Although elder abuse has existed throughout time, only in the most recent decades have researchers and literature begun to seriously address the issue. The intent of this review of literature is to explore elder abuse through a synopsis of current readings that address relevant issues. As a flux of recent research and literature indicate, it is overdue that the age-old problem of elder abuse be focused upon and brought to light.

Defining Elder Abuse

Many types of abuse construe the definition of elder abuse. In general, elder abuse may be defined as any physical, psychological, or material abuse toward an elderly person. Additionally, violation of the elder's right to safety, security, and adequate health care constitutes elder abuse (Anderson, Glanze, & Anderson, 1998, p. 2DE8). However, agreement on a specific definition of elder abuse is lacking. This is exemplified by the variations in defining elder abuse within the adult abuse laws of the 50 States (Goodrich, 1997) and the definitions used by individual researchers (Hudson & Carlson, 1998).

A national survey of state adult protective services programs revealed that a wide variation

exists in state protective programs with dissimilarities in structure, administration, age of client eligibility, type of abuse and abuse definitions, and reporting requirements (Goodrich, 1997). These differences result from the absence of federal mandates and the States having developed their own definitions and laws in response to elder abuse, neglect, and exploitation. Without the States having uniformed protective services and using a single definition of elder abuse, the compilation of national incidence data from state data would be difficult, if not impossible at this time. At this time, the prevalence of abuse among elderly people is unknown (Macdonald, 1997).

Types of Elder Abuse

Without a clear and unified definition of elder abuse, several underlying themes have prevailed. Physical, sexual, verbal, psychological, social, and spousal abuse, financial exploitation, and neglect and self-neglect recurrently appear in recent literature concerning elder abuse (Childs, Hayslip, Radika, & Reinberg, 2000; Hudson & Carlson, 1998; Mumper, 1998; Nandlal & Wood, 1997; Wolf, 2000).

Physical Abuse. Physical abuse is a broad classification of abuse that is the result of the

infliction of physical pain or injury (Wolf, 1996). This may include restraining, slapping, hitting, bruising, and other forms of physical abuse that result in pain or injury. Sexual abuse, sexually molesting, and raping an elderly person, are acts that are not only physically abusive, but also psychologically abusive as well.

Verbal/Psychological Abuse. Verbal abuse or psychological abuse is characterized by inflicting mental anguish (Wolf, 1996). Humiliation, intimidation, yelling, and threats are some of many examples of verbal abuse. Keeping an elderly person isolated from others can also cause psychological distress and lead to more serious issues such as depression.

Financial Abuse. The illegal or improper exploitation and use of funds of an elderly person denote financial abuse (Wolf, 1996). Theft, fraud, and taking advantage of a cognitively impaired older person for profit or personal gain constitute financial abuse. Financial abuse of the elderly tends to occur overtime rather than a single, overt act such as robbery, purse snatching, or car jacking (Wilson & Reynolds, 1996).

Spousal Abuse. Spousal abuse can occur throughout the adult life span. Harris (1996) found that although the incidence of spouse abuse in older couples is significantly less than that of younger couples, the risk factors associated with spousal abuse are the same regardless of age. For older people who report physical abuse from a spouse, the abuse has likely occurred for many years throughout the relationship and continues into the elderly years. For others, spousal abuse may occur with a significant life change that sometimes accompanies older age, such as mental or physical illness of a spouse. In addition, other forms of domestic violence, including family relationships with longtime partners, adult children, and grandchildren have resulted in elder abuse (Brandl, 2000).

Neglect/Self-Neglect. Neglect by others or by oneself is characteristic of elder abuse. Refusing or failing to fulfill care-taking obligations,

abandoning an elderly person, or denying food or health services are forms of neglect (Wolf, 1996). Self-neglect may include not fulfilling activities of daily living although physically able to do so. This may include not eating, bathing, and taking medications, or seeking necessary health services. Neglect and self-neglect may be due to intentional acts with the conscious attempt to inflict pain and suffering or may be unintentional due to ignorance, infirmity, or laziness on the part of the person responsible (Wolf, 1996).

Varying Perceptions of Elder Abuse

In attempt to more definitively define elder abuse, researchers have explored these broad categorizations of abuse. Outcomes of the abusive act and perceptions of abuse have been the focus of some studies. A compilation of defining elements within some of the recent literature related to these studies is presented here.

Hudson and Carlson (1998) set forth to gain greater precision in the clarification and definition of elder abuse by comparing the perspectives of a group from the general public with those of a group of experts with regards to elder mistreatment. Both groups identified physical, psychological, social, and financial abusive factors. Conditions noted as severe abuse by both groups all involved examples of physical force. Furthermore, the context in which the behavior occurred affects the interpretation of it. Thus, creating valid and reliable operational definitions of elder abuse remains challenging because it is difficult to build complete context into a single definition.

Studies have demonstrated variations in what constitutes elder abuse as perceived by different age groups. Childs et al., (2000) found that age influenced perceptions of elder abuse in that middle-aged and young people view elder abuse differently. Although younger and middle-aged people were equally likely to identify physical abuse and its harmful effects, middle-aged people were more likely to also recognize psychological abuse. Both age groups viewed physical abuse as more harmful to the victim than psychological abuse. However, middle-

aged adults were more likely to perceive psychological abuse as being harmful to the victim than younger adults.

Blakely and Dolon (1998) revealed that young adults don't believe that they are ever going to encounter a case of elder abuse and suggested that they are less likely to be receptive to recognizing elder abuse and to report it. Additionally, they proposed that young adults just assume that older adults remain invisible because of many negative stereotypes toward the elderly. It is suggested by these research findings that young adults are much less likely to recognize abuse among the elderly.

When elderly participants in a study by Nandlal and Wood (1997) were asked, "what does abuse mean to you," responses were varied and indicated a number of types of abuse. Consequences of the abusive behavior affected participants' perceptions of the severity of the abuse more so than the frequency of the abuse. This is contrary to much discussion in current literature that suggests context and frequency of abusive behaviors are factors for interpreting behavior as abusive or not (Childs et al, 2000; Hudson & Carlson, 1998; Wolf, 2000).

In attempt to further gain an understanding of what elder abuse means, a number of studies have looked at elder abuse in relation to cultural affiliation. Hudson, Beasley, Benedict, Carlson, Craig, and Mason (1999) compared four African-American groups with each other and with the views of a panel of elder mistreatment experts. The African-American groups and the expert panel highly agreed on 19 of 26 items that characterized elder abuse. All groups also indicated a high degree of support for all categories of elder abuse and its theoretical definition with the exception of the issues of frequency and intensity as determinants for labeling behavior as abusive. The expert panel indicated that abuse is defined by terms "of sufficient frequency and/or intensity," whereas, the African-American groups viewed a single act as being abusive and that frequency and intensity relate to determining the severity of the abuse.

In a similar analysis by Hudson, Armachain, Beasley, and Carlson (1998), responses of two groups of Native Americans were compared with each other and the responses of the same expert panel previously mentioned. The Native American groups also strongly agreed with the expert panel in that the behaviors exhibited toward elders on the Elder Abuse Vignette Scale were not acceptable and the majority of behavior examples were labeled as abusive. The Native Americans clearly indicated that elders should be treated with honor and respect, as well as cared for and cared about. This may relate to holding true historical Native American cultural norms of respect for elders. The Native American groups also identified one occurrence of any abusive behavior as being sufficient for determining elder abuse as opposed to the proposed definition of the expert panel that views elder abuse being dependent on it occurring with "sufficient frequency and/or intensity."

A pilot, explorative study by Le (1997) investigated perceptions of mistreatment among Vietnamese elderly living in America. Four areas of abuse were explored: verbal, emotional, financial, and physical abuses. Among this study's participants, no physical abuse was identified. Verbal and emotional abuses were most often reported. Unique to the majority of Vietnamese elders living in America is that many of them only recently immigrated to the United States within the past two decades. Many of the Vietnamese elders living in the United States reported being unhappy, even in the absence of any abuse or mistreatment. Many of the Vietnamese elders are not proficient in the English language, are more likely unaware of public services, and dependent on family. These factors, along with longing for their homeland, place Vietnamese elders at increase risk for depression and hence, self-neglect. Furthermore, difficulties with acculturation may lead to increase risk for elder abuse.

After reviewing research related to cultural similarities and dissimilarities in relation to elder abuse, Moon (2000) suggested that rather than ethnicity, acculturation and socioeconomic factors may offer more powerful insights into

perceptions of elder abuse among ethnic minorities. Factors such as place of birth, age at immigration to America, length of residence in the United States, proficiency in English, familiarity with American laws and protective services, income level, educational level, and living arrangement may be more influential than ethnicity in defining elder abuse. Overemphasizing cultural differences without regard to other factors may be more detrimental than helpful if non-cultural issues related to elder abuse are ignored when addressing elder abuse situations among ethnic minorities.

Associated Risk Factors for Elder Abuse

Just as defining elder abuse has proven to be a challenge with many variations on what constitutes elder abuse, risk factors associated with it have been identified, yet a consensus among research has not been achieved. Compounding the issue of risk factor identification, a lack of research pertaining to associated risk factors for elder abuse exists. Among the few studies pertaining to risk factors, certain socio-demographic characteristics appear to correlate with risk for elder abuse. Jogerst, Dawson, Hartz, Ely, and Schweitzer (2000) found that areas with higher incidence of substantiated elder abuse were correlated with demographic factors of population density and child poverty. The greater the population density and the number of children living in poverty in a given area, the more likely elder abuse occurred.

Lachs, Williams, O'Brien, Hurst, and Horwitz (1997) investigated a cohort of community-dwelling older adults associated with elderly protective service records spanning a nine-year period. Analyses of these records revealed that age, race, poverty, functional disability, and cognitive impairment were risk factors for reported elder mistreatment. Non-Caucasian, low-income, and advanced age socio-demographic features were significantly associated with reported elder abuse and neglect. Additionally, existing impairments and number of impairments with activities of daily living were identified with increase risk for elder abuse. The onset of new cognitive impairment was also found to be associated with elder abuse and neglect. Furthermore, Cupitt (1997) found

that among the study's sample, the largest proportion of abuse occurred among those in the 76-80 years category with almost half living alone.

Among a population-based sample of independently living elderly in Amsterdam, Comijs, Smit, Pot, Bouter, and Jonker (1998) examined risk indicators in relation to verbal aggression, physical aggression, and financial mistreatment. Results indicated that elderly people in poor health living with a partner or others were more likely to experience chronic verbal abuse. An association was also found between depression and physical aggression. Elderly people with symptoms of depression and who live with others were more likely to be subjected to acts of physical aggression. Contrary to verbal and physical acts of abuse, financial mistreatment was more associated with the elderly who live alone.

Studies of the 1970s and 1980s have reported that women were most likely to be reported as the victims of elder abuse. As is with most studies about abuse, men are under-studied. This is particularly true of elderly men. In a review of literature, Kosberg (1998) presents the case that elderly men are at risk for elder abuse and provides a typology based upon high-risk lifestyles, domestic living arrangements, belonging to a racial minority group, quality of care in institutions, and self-neglect. Kosberg (1998) identifies high-risk lifestyle as being associated with living alone due to recent widowhood, never marrying, or divorce. Elderly men who live alone tend to have shorter life expectancies related to physical and emotional problems resulting from self-neglect. Elderly men are also potential victims of abuse from spouses, life partners, adult children, and grandchildren, especially in cases of physical and mental disabilities.

Lesbian, gay male, bisexual, and transgendered elders may be at risk for abuse not only due to reasons associated with elder abuse in general, but also because of their sexual orientation or gender identity. Societal prejudice against and ignorance about sexual orientation and gender minorities has precluded research related to

these groups and elder abuse issues. Cook-Daniels (1997) suggested that these individuals are likely to be more resistant than others to accepting social services because of social prejudices and stereotypical attitudes.

Perpetration and Situations of Elder Abuse

In addition to recognizing risk factors for elder abuse, understanding and identifying characteristics of offenders of elder abuse may assist with addressing the problem of elder abuse and mistreatment. As a theoretical tool to assist with understanding who abuses and why, Ramsey-Klawnsnick (2000) proposed a typology of offenders postulated by five types: 1) the overwhelmed, 2) the impaired, 3) the narcissistic, 4) the domineering or bullying, and 5) the sadistic.

Overwhelmed offenders begin as caretakers with the intention to provide adequate care (Ramsey-Klawnsnick, 2000). However, when the amount of care required exceeds the caretaker's stress level and capabilities to provide care, the overwhelmed offender verbally or physically lashes out. This may also lead to the quality of care provided deteriorating, sometimes to the point of neglect.

Impaired offenders are individuals who are well intentioned, but have problems that make them unqualified or unable to provide care for a dependent elderly person (Ramsey-Klawnsnick, 2000). Impairments may include advanced age and frailty, physical and/or mental illness, and developmental disabilities of the caretaker. Impaired offenders typically fail to realize that mistreatment of the dependent elder is occurring because of their own impairment. Neglect, improper use of medicines, and mismanagement of finances often result from impaired caretakers caring for the dependent elderly (Comijs et al, 1998; Ramsey-Klawnsnick, 2000). Physical and verbal abuse may occur as a way of trying to control or correct the dependent elder.

Narcissistic offenders of elder abuse are motivated by personal gain, not a desire to help elderly dependents (Ramsey-Klawnsnick, 2000). They are self-centered and use other people and their assets. They treat elders like objects or as a

means to an end, which may include inheriting the elderly person's possessions, receiving their Social Security or pension check, or exploiting other valuables. Neglect and financial exploitation are the most common abusive behaviors by narcissists. The abuse tends to intensify over time.

Domineering or bullying offenders feel justified in blaming and attacking others (Ramsey-Klawnsnick, 2000). This is particularly the case with those whom they feel they have power and authority over. Outbursts of rage and misuse of trusting relationships to justify coercive or forceful behavior typifies the domineering offender. They tend to rationalize that the victim "asked for it" or "deserved it" because of the offender's rigid expectations not being met. Domineering abusers can be of particular danger to elderly people who are not able to meet their own needs, yet alone the offender's.

Sadistic offenders are characterized by feelings of power and importance derived from humiliating, terrifying, and harming others (Ramsey-Klawnsnick, 2000). They are extremely dangerous, often having socio-pathic personalities, lacking guilt, shame, or remorse for their behavior. They inflict severe, chronic, and multifaceted abuse. Torture, mutilation, and murder sometimes result from sadistic abuse.

Anetzberger (2000) proposes an alternative model for explaining elder abuse. The Explanatory Model for Elder Abuse theorizes that elder abuse is primarily a function of the perpetrator's characteristics and secondarily a function of the victim's characteristics. Caregiving serves as a contextual framework for victim-perpetrator interaction. The dynamics related to caregiving, including the victim-perpetrator interaction and the situation, along with other contexts, such as intimate relationships, isolation, and accessibility to valuables, trigger abuse.

In addition to personalities and individual characteristics of abusers, situations or environmental settings sometimes lend to elder abuse. Older persons living in community and health care settings are at risk for abuse and

neglect. Elder abuse within institutional settings may result from the vulnerability of the elderly due to frailty, physical and mental illnesses, and inadequate training and experience of caregivers. Furthermore, nursing home staff may abuse elderly persons who display aggressive behaviors (Shaw, 1998).

Shaw (1998) identified two types of nursing home staff abusers, the reactive and the sadistic abuser. The reactive abuser has either never developed or has lost immunity to residents' aggressions and thus, reacts to immediate situations of aggressive behavior in abusive ways. The sadistic nursing home abuser intentionally and systematically abuses residents of nursing homes.

Institutional abuse and neglect are multifactorial in origin. Nursing home staff are not only confronted with aggressive behaviors from residents who suffer from varying forms of dementia and illnesses, but must also balance this with their own personal stressors, which may include family problems, physical and emotional exhaustion, problems at work, substance abuse, and history of involvement in domestic violence (Shaw, 1998).

The nursing home environment may also contribute to elder abuse and neglect. Expectations and multiple demands placed on caregivers in a harsh and oppressed environment increases the likelihood of nursing home workers to react in abusive manners. Inadequate numbers of staff contribute to poor care plagued with neglect. Treatment of nursing home aides as dehumanized, replaceable objects who are discounted and oppressed increases the likelihood of abuse in nursing home settings (Shaw, 1998). Furthermore, poorly trained staff adds to elder neglect and abuse in residential care facilities.

Recognizing Elder Abuse

Recognizing elder abuse is not only important for stopping harm among the elderly, but is also critical for reducing mortality rates. Lachs, Williams, O'Brien, Pillemer, and Charlson, (1998) reported that at the end of a 13-year study, follow-up with cohort members identified

with confirmed mistreatment had poorer survival rates (9%) than either those seen for self-neglect (17%) or other non-mistreated cohort members (40%). Thus, recognizing elder abuse and intervening are important for reducing morbidity and mortality among elderly people due to elder abuse, whether that be abuse by others or self-neglect.

Recognizing abuse in the elderly is possible by various means. In particular, healthcare providers, social workers, and service providers play critical roles in identifying elder abuse. Warning signs of elder abuse include: bruises, welts, burns, lacerations, or scars; fractures; bruising about wrists due to being restrained; bilateral injuries; injuries present at various stages of healing; overmedicating or undermedicating; unexplained sexually transmitted diseases; dehydration; malnutrition; decubitus ulcers; poor personal hygiene; lack of compliance with medical regimens; unexplained delay in getting medical attention; repeat visits to a physician's office or emergency department for similar injuries; and extreme withdrawal, depression, or agitation (Butler, 1999; Wolfe, 1998).

Physical signs of abuse are more obvious upon examination of an elderly person who has been physically abused. However, care must be taken to thoroughly evaluate injuries or other physical signs. In some cases, some elderly people tend to bruise or sustain injuries from normal daily activities (Baladerian, 1997). Additionally, signs and symptoms of elder abuse can be masked by normal effects of aging, disease pathology, and functional limitation (Gray-Vickrey, 2000). Therefore, thorough assessment is necessary when evaluating physical signs and symptoms among older adults. Other physical effects resulting from elder abuse may be sleep disturbances, eating problems, and recurring headaches (Anetzberger, 1997). Clear, direct communication is essential when assessing physical problems in order to identify the underlying cause, whether they are physical, mental, or abusive in nature.

Marshall, Benton, and Brazier (2000) suggest that clinicians should complete a comprehensive

physical examination and history in order to gather clues that may be suggestive of elder abuse. Additionally, the U.S. Preventive Services Task Force (2004), also known as USPSTF, suggests that clinicians should be alert to physical and behavioral signs and symptoms that are associated with abuse or neglect. Questions should be asked in plain language in a nonjudgmental manner. Often volunteering information is the exception, so it is imperative for providers to ask direct questions and listen for subtleties that may lead to further questions that will illicit additional information. Careful documentation should be done throughout the care of the individual, which later may be used to assist with substantiating abuse upon investigation. In addition to a thorough history and detailed documentation, photographs and body maps depicting physical abuse should be obtained along with providing the victim with appropriate referrals for counseling, protective services, crisis centers, and shelters (USPSTF, 2004).

Abuse and neglect may manifest through behavior as well. It is important upon assessing an elderly person to consider the demeanor and mental status of the individual (Wolfe, 1998). Comijs et al. (1999) found that victims of elder mistreatment had significantly higher levels of psychological distress than non-victims. Appearing fearful, withdrawn, nervous, agitated, angered, passive, embarrassed, dissociated, or depressed, along with the quality of interaction with caregivers may indicate the possibility of elder abuse. Feelings of suicide and helplessness may also be indicative of abuse (Anetzberger, 1997). Depression and dementia are of particular importance to identifying elder abuse. Dyer, Pavlik, Murphy, and Hyman (2000) found that elderly people victimized by neglect tend to have higher prevalence of depression (62% vs. 12%) and dementia (51% vs. 30%) than patients seen for other reasons.

Few screening tools have been developed and validated for assisting with the recognition of elder abuse in the clinical setting. Nelson, Nygren, McInerney, and Klein (2004) reviewed literature that included screening instruments for recognizing abuse among elder persons and

searched for possible adverse effects of performing screenings. Based on their inclusion criteria, they found three studies out of 1,045 abstracts identified by database searches that contained tested instruments for the assessment of elder abuse. Of these assessments, none were tested in clinical settings, but were considered because they had possible clinical applications. However, not one study was found that addressed the potential adverse effects of screening. It is important for those who work with the elderly to recognize the potential harm may come from screening if care is not also taken to administer appropriate action if abuse is suspected.

Often not thought of when screening for abuse is the problem of financial exploitation and abuse of the elderly. A variety of factors are associated with recognizing financial abuse. Elders may be financially exploited if they are withdrawing large sums of money from a bank while accompanied by a stranger or is being coerced to do so by a family member. Another sign of financial exploitation may include the elderly person giving implausible explanations for what they are doing with their money. Confusion or concern about missing funds from an account may be a warning sign of the possibility of financial abuse by others. Also, elders who are fearful of being evicted or institutionalized if money isn't given to a caregiver may be victimized by financial exploitation (Price & Fox, 1997).

Responding to and Reporting Elder Abuse

Often, someone other than the elderly victim reports suspected cases of elder abuse. This may be due to the elderly victim not recognizing that abuse is occurring, fear that greater abuse may occur if something is said, dependence on the abuser, or not knowing available resources for help. Wood and Stephens (2003) found that an average of 25% of assisted living residents within their study had poor awareness of available support services for the elderly. Furthermore, although 54% were able to identify abusive situations, they had difficulty with generating appropriate strategies for handling the abusive situations. It is likely that older

people need the assistance of others with responding and reporting elder abuse.

Throughout the nation, there has been an increase in the number of reports, investigations, and prosecutions of occurrences of abuse, neglect, mistreatment, and financial exploitation of the elderly (Hodge, 1998). In response to elder abuse, legislative initiatives have been enacted in each state as in the case of child abuse (Morris, 1998). These laws have been designed to protect elderly people against abuse, neglect, and financial exploitation. Healthcare providers, human service providers, and social workers should become familiar with their state's laws, definitions, and reporting obligations.

The majority of states require human and social service and healthcare providers to report suspected cases of elder abuse. Those states that don't mandate reporting encourage it (Morris, 1998). Forty-two states and the District of Columbia have statutes that require specified professionals to report suspected mistreatment and abuse of older adults (Moskowitz, 1998). A provider does not have to be certain of abuse occurring, only suspicious of possible abuse. The standard for reporting is based on a reasonable belief that a vulnerable adult has been or is likely to be abused, neglected, or exploited.

Reporting suspected abuse is important not only for the welfare of the potentially abused older adult, but for the provider as well. Most states provide protection from civil or criminal liability for reporting alleged elder abuse that is unfounded. Additionally, failure to report suspected abuse in some states may result in the provider being charged with a misdemeanor and reported to their licensing or professional governing board for disciplinary actions (Morris, 1998). To make a report of suspected abuse, each provider should be familiar with the specific regulations of their state and of the facility for which they work. Typically, a State's Adult Protective Services Agency is the point of contact for reporting alleged elder abuse. Investigation of suspected abuse usually includes an ombudsman, human service

providers, and sometimes the police as well (Morris, 1998).

Although not all States require health professionals to report suspected or actual cases of abuse, Jogerst, Daly, Brinig, Dawson, Schmuch, and Ingram (2003) found that higher investigation rates were associated with mandatory reporting requirements and statutes that imposed penalties for failure to report elder abuse. Thus, report rates and substantiation rates of elder abuse among the States may not be truly reflective of the actual rates of elder abuse that are occurring. In states where mandatory reporting is not required, actual rates of elder abuse may be quite different from what has been reported.

When responding to elder abuse, it has been suggested that police officers should respond differently than they do to child abuse reports. This is particularly due to the respect that must be given to the victim's right to self-determination, which is very different from giving consideration to a child's preferences (Plotkin, 1996). During an interview with the older victim of abuse, it is important for the police officer to ask clear questions that do not imply abuse by a particular person who may be a caregiver. Such judgmental implications are likely to result in the older person not revealing necessary details because of fear or emotional ties to the caregiver (Formby, 1996). Additionally, consideration must be given to the fact that options for abused adults may be limited. Victims may depend on their abusers for daily activities of living and arresting an alleged abuser could result in institutionalization of the elder. A multi-disciplinary approach to include law enforcement, human services, and health care providers is more likely to detect elder abuse and result in effective intervention. Interdisciplinary geriatric assessment and intervention by a variety of healthcare and social service providers is an effective procedure for identifying, diagnosing, and creating care plans in response to and as an intervention for elder abuse (Dyer & Goins, 2000).

Further consideration must be given to the reluctance of the current elderly population to

take legal action against or see criminal charges brought against a family member for whom they feel love or responsibility, caregivers for whom they depend on, friends, neighbors, or others whom they care for or have placed their trust in (Stiegel, 2000). Besides the reluctance of older victims to report, elder abuse is often difficult to prove because of delays or failures to recognize that abuse is occurring. In the meanwhile, physical evidence may disappear or not be available, witnesses disappear, information is forgotten, or the victim dies (Heisler, 2000). Thus, significant changes and ongoing pursuits related to case law are necessary for appropriate legal response to elder abuse.

Interventions and Elder Abuse

Besides legislative initiatives, service interventions and their outcomes in response to elder abuse have recently been investigated. A common social service outcome measure is case resolution. Wolf and Pillemer (2000) assessed case resolution among a group of elder abuse cases and found that resolved cases were more likely than unresolved cases to be associated with neglect, increased social support for victims, stress reduction, reduction of dependency on the perpetrator, and a change in living arrangements for the victim. These results may be indicative of elements to be included in intervention programs, however consideration should be given to the relatively small sample size of only 59 cases analyzed by this study.

When first alerted to elder abuse in the early and mid 1980s, many states chose to build upon their existing adult protective services programs, which had been modeled after the child abuse reporting and response system (Nereberg, 2000). This child abuse model enlisted the help of professionals who are likely to come in contact with the abused to report suspected cases of child abuse. However, when suspecting elder abuse, there is a difference. When abuse is suspected among children, the state can step in and assume parental authority. The model assumes that children are incapable of making decisions about their own welfare because of their immaturity. With adults, this is not the case and this distinction has plagued the protective-services approach ever since. It has proven to be

extremely problematic in proving that adults are not capable of making decisions about their own welfare. Thus, the protective-services system offers limited options for abused older persons.

Involuntary protective services may be rendered as an intervention by adult protective service workers, without the consent of the affected adult, when it is deemed that the adult is at risk of abuse, neglect, or exploitation. These services are involuntary because they result from the recipient not having the capacity to consent to services, the lacking of a person to consent on behalf of the person in need of services, or the services being ordered by the court. However, a national survey revealed that less than 10% of recipients of adult protective services receive services without their consent (Duke, 1997). Furthermore, the results of this study suggested that individuals who are victims of self-neglect are not being identified and are not more likely to have protective services imposed upon them as is generally believed.

Anetzberger, Palmisano et al., (2000) reported on a 2-year collaborative project that improved the reporting and management of suspected elder abuse involving persons with dementia in Cleveland, Ohio. Project members developed an education curriculum with cross-training, identified screening tools for dementia to be used, and created a handbook for caregivers to self-assess risk of elder abuse and to identify referral resources. Within one year of implementation of this program, reports of suspected abuse among older persons with dementia significantly increased.

Some proposed interventions in relation to detecting elder abuse in nursing home settings have been developed and investigated. A national survey of the Nation's Offices of Attorney Generals and the Medicaid Fraud Control Units, which investigate and prosecute patient abuse cases, revealed that current law enforcement and resources are inadequate to meet the increasing aging population's needs (Hodge, 1998). As the older population continues to increase and more reside in nursing homes, it is important to have adequate law

enforcement to protect against elder abuse in residential and healthcare facilities.

After serving as expert witnesses in a trial against a nursing home corporation for the involuntary manslaughter of two residents, Capezuti and Siegler (1996) recognized the need for improving the quality of care of nursing home residents through education. An educational video was developed to acknowledge the existence of elder abuse, recognize signs of mistreatment, evaluate elder mistreatment, address liability issues, and identify referral sources in cases of suspected nursing home mistreatment. At this time, empirical evidence of the effectiveness of the video intervention has not been evaluated. So, it is not known as to the effectiveness of reducing nursing home mistreatment by presenting an education-based video to nursing home staff.

Braun, Suzuki, Cusick, and Howard-Carhart (1997) reported on a training video developed to be presented as part of an elder abuse workshop for nurse aides in Honolulu, Hawaii. The video was developed in accordance to what nursing home workers previously stated as concerns in nursing homes and for staff. Workshop participants completed a pre-workshop survey that assessed their job satisfaction. After viewing the video, small group discussions were held for sharing how the nurse aides handled various situations and stress at work. An immediate post-survey revealed higher ratings for increased job satisfaction. From this study, it was proposed that nurse aides desire recognition for their work and more training on conflict resolution.

Author's Final Thoughts on Elder Abuse

As has been denoted within this review of literature, a number of barriers exist that inhibit prevention and intervention initiatives related to elder abuse. First, without a clear, unified definition and mandate for handling cases of

suspected elder abuse, it is not possible to assess the prevalence of abuse among elderly people. Second, varying perceptions exist as to what constitutes elder abuse. Perceptions vary by age, race, cultural beliefs, acculturation, and residential setting. Third, due to factors associated with victim-perpetrator relationship, dependency of the elder on a caregiver, fear and anxiety, and other related factors, abused older people may be unlikely to report cases of elder abuse. Fourth, elder abuse is perpetrated in a number of ways. Although elder abuse may be intentional, the majority of elder abuse is done unintentionally by caregivers with good intentions but become overwhelmed or are incapable of providing appropriate care. Furthermore, not all abuse is perpetrated by another person. Some abuse is due to self-neglect.

There is a lack of interventions developed for the prevention of elder abuse. Most interventions that have been reviewed or evaluated are reactive in nature, that is, they focus on responding to elder abuse rather than preventing it in the first place. Those interventions that have been recognized in literature related to elder abuse are limited in their evaluation of effectiveness.

Suggestions for the future include definitively defining elder abuse, creating and evaluating prevention programs, and addressing interventions for abused elders. Empirical research is needed to address each of these issues. Voelker (2002) supports that more scientific research is needed as for much of the existing literature is anecdotal. Until then, elder abuse will remain as an age-old problem brought to light with only a dim flicker. Elder abuse deserves the attention due to it so that this problem is illuminated by research that will prevent elder abuse among an aging population and provide more effective interventions for those affected by this plague against our elderly.

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